COMMONWEALTH OF KENTUCKY

907 KAR 1:090
Incorporation by Reference

MAP 1 O-P, Kentucky Medicaid Program
Personnel Care Assistance Waiver Services
January 2000 Revision

MAP-350, Long Term Care Facilities and Home and
Community Based Program Certification Form
January 2000 Revision

MAP 4100P, Personal Care Assistance Waiver Services,
Provider Information and Services
January 2000 Revision

MAP-9, Commonwealth of Kentucky, Cabinet for Human Resources,
Kentucky Medicaid Program,
Prior Authorization for Health Services
December 1995 Revision

DSS 891-1,2, The Plan of Care
July 1996 Revision

The State of Kentucky, Aging Services
Client Enrollment
January 2000 Revision

MAP-24, Commonwealth of Kentucky,
Cabinet for Families and Children,
Department for Community Based Services
January 2000 Revision

Cabinet for Health Services
Department for Medicaid Services
Division of Long Term Care
275 East Main Street 6W-B
Frankfort, Kentucky 40621

MAP 10-P (Rev. l-2000)

KENTUCKY MEDICAID PROGRAM
Personal Care Assistance Waiver Services

TO:

AGENCY: _____

ADDRESS: _____

_____ PHONE: _____

PHYSICIAN'S RECOMMENDATION

I recommend the Personal Care Assistance Waiver Services Program for:

CLIENT:

_____

ADDRESS: _____

_____ PHONE: _____

SOCIAL SECURITY# _____ MAID # _____

DIAGNOSIS(ES) _____

_____

I understand that the Personal Care Assistance Waiver Services Program includes the following services, provided as needed: assessment / care planning, reassessment, case management, personal care assistance (which includes a business agent function), and program coordination.

I certify that if Personal Care Assistance Waiver Services were not available, nursing facility placement shall be appropriate for this individual in the near future.

PHYSICIAN'S NAME: _____ UPIN# _____

ADDRESS: _____

_____ PHONE: _____

_____

SIGNATURE DATE

LONG TERM CARE FACILITIES AND HOME AND COMMUNITY BASED PROGRAM CERTIFICATION FORM

I. ESTATE RECOVERY

Pursuant to the Omnibus Budget Reconciliation Act (OBRA) of 1993, states are required to recover from an individual's estate the amount of Medicaid benefits paid on the individual's behalf during a period of institutionalization or during a period when an individual is receiving community based services as an alternative to institutionalization.

In compliance with Section 1917 (b) of the Social Security Act, estate recovery will apply to nursing facility long term care services (NF, NF/BI, ICF/MR/DD), home and community based services that are an alternative to long term care facility services and related hospital and prescription drug services.

Recovery will only be made from an estate if there is no surviving spouse, or children under age 21, or children of any age who are blind or disabled.

I certify that I have read and understand the above information.

Signature Date

II. HOME AND COMMUNITY BASED WAIVER SERVICES .FOR THE AGED AND DISABLED, PEOPLE WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES, MODEL WAIVER II, BRAIN INJURY WAIVER

A. HCBS - This is to certify that l/legal representative have been informed of the HCBS waiver for the aged and disabled. Consideration for the HCBS program as an alternative to NF placement is requested _____; is not requested _____.

Signature Date

B. This is to certify that l/legal representative have been informed of the home and community based waiver program for people with mental retardation/ developmental disabilities. Consideration for the waiver program as an alternative to ICF/MR/DD is requested _____; is not requested _____

Signature Date

C. MODEL WAIVER II - This is to certify that l/legal representative have been informed of the Model Waiver II program. Consideration for the Model Waiver II program as an alternative to NF placement is requested _____; is not requested _____

Signature Date

D. BRAIN INJURY (BI) WAIVER - This is to certify that l/legal representative have been informed of the BI Waiver Program. Consideration for the BI Waiver Program as an alternative to NF or NF/BI placement is requested _____; is not.requested _____.

_____ _____
Signature Date

III. FREEDOM OF CHOICE OF PROVIDER

I understand that under the waiver programs, I may request services from any Medicaid provider qualified to provide the service and that a listing of currently enrolled Medicaid providers may be obtained from Medicaid Services.

_____ _____
Signature Date

IV. RESOURCE ASSESSMENT CERTIFICATION

This is to certify that l/legal representative have been informed of the availability, without cost, of resource assessments to assist with financial planning provided by the Department for Community Based Services-

_____ _____
Signature Date

V. RECIPIENT INFORMATION

Medicaid Recipients Name: _____

Address of Recipient: _____

_____

Phone: _____

Medicaid Number: _____

Responsible Party/Legal Representative: _____

Address: _____

_____

Phone: _____

Signature and Title of Person Assisting with Completion of, Form:

_____

Agency/Facility: _____

Address: _____

MAP- 41 OOP (Rev. 01/2000)

PERSONAL CARE ASSISTANCE WAIVER SERVICES
PROVIDER INFORMATION AND SERVICES

PROVIDER NUMBER: _____

AGENCY NAME: _____

AGENCY ADDRESS: _____
STREET OR P.O. BOX

_____
CITY, STATE, ZIP CODE

FROM THE FOLLOWING LIST, PLEASE CHECK EACH SERVICE FOR WHICH YOU WILL BE SUBMITTING CLAIMS:

1. _____ Case Management .
(If this item is checked, this provider may bill for no other services)

2. _____ Personal Care Assistance/ *Business Agent Function
(*Payroll and accounting function for paying the personal care assistant)

3. _____ Personal Care Program Coordination

By signing below I, _____, *certify that this agency is capable of and* agrees *to comply with the conditions for participation established in the Personal Care Assistance Services Waiver and regulation 907 KAR 1:090. In addifion, I certify that* all sfaff shall *meef all training requirements prior to fhe provision of services.*
Authorized Representative

_____ _____
SIGNATURE OF AUTHORIZED REPRESENTATIVE / TITLE DATE

-9 (REV 12/95)

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
KENTUCKY MEDICAID PROGRAM
PRIOR AUTHORIZATION FOR HEALTH-SERVICES

1. Med. Assist. I.D. No. (Ten Digits)	2. Recipient Last Name:	3. First Name:	4. M.I.
5a: Provider Number (Eight Diaits)	6a. Provider Name. Address, and Phone Number		7. Co. # of Recipient Residence:
5b. Provider Number (Eight Digits)	6b. Provider Name, Address, and Phone Number		8. Date of Delivery (if already delivered)
9. Primary Diagnosis:			11. Date of Birth MM DD YYYY
10. Secondary Diagnosis:			

Signature of Provider. | Date: | **Caution:** n r for you to receive payment, the recipient must be eligible on the date of service. **Check The Medicaid Card.**

12. tine No.	13. Procedure/ Supply Description	14. Procedure Supply Code	15. Units of Service	16. Usual and Customary Charges	17. Medicaid Action A =Approved D=Disapproved	18. Approved Amount'
01.						
03.						
04.						
05.						
06.						

19. HCB and Model Waiver Providers enter Approximate Total Monthly Charge:
$_____

DO NOT WRITE BELOW THIS LINE

20. Reason For Denial:

21.. Other Comments:

22. Prior Authorization Number:	23. Approval Dates:	24. Type of Service Authorized:
Mailroom Use:	From:	40____DME
	Through:	41____MODEL WAIVER
		45____EPSDT/SPECIAL SERVICE
		46HOME HEALTH
		52H.C.B.
		52 8 53 ____H.C.B & A.D.C
		72 ____DENTAL
		, ____OTHER
'Not used by H.C.B Waiver/Model Waiver		

Signature of Medicaid/Prior Authorization Respresentative:

Date:

'lease refer to your billing instructions for the appropriate address.

PLAN OF CARE

Client _____ Initial Date of Plan of Care _____ Estimated Duration

Date Reassessment Due _____

Continuation of Plan of Care Date _____

Identified Problem or ed (Describe in nctional terms)	Goals	Services	Provider Formal/Informal Units/time funding source
Physical: (health: nutrition; ADLs: IADLS)	___ Enhance/or maintain client in current living arrangement ___ Establish/maintain personal hygiene ___ Enhance or/maintain highest level of functioning ____ Other _____	**PERSONAL CARE** Bath (sponge, tub) Nails ____ Bed making ____ Hair/shampoo ____ Mouth Care. Teeth/Dentures Transfer patients to chair Assist with walking Assist with dressing Assist with toileting Shave Exercise Other	___ Units of PC ___ x weekly Day _____ Funding _____
			___ Units of PC ___ x weekly Day _____ Funding _____
		_____ **ESCORT**	___ Units of escort ___ x weekly Day _____ Funding _____
l . .cal aides/ environment: (equipment/ household)	___ Establish/enhance/maintain clients nutritional status ___ Establish/enhance/maintain clients independence ___ Establish/enhance or maintain a clean and safe environment ____ Other _____	**NUTRITION** Teaching Home Delivered Meals. Frozen Meals Meal Preparation Congregate Meals Other	___ Units of meals ___ x weekly Day _____ Funding _____
			___ Units of meals x weekly Day _____ Funding _____
		HOME HEALTH AIDE _____ B/P _____ Exercises _____ Skin Care _____ Ds . _____ Diabetic routine _____ Foley cath. care _____ Appliances (Artificial limbs) _____ Other	___ Units of HHA ___ x weekly Day _____ Funding _____
		HOMEMAKER _____ Laundry _____ Shopping _____ Sweep/Mop/Dust ___ Bedroom ___ Bathroom ___ Living ___ Kitchen _____ Dishes _____ Teaching	___ Units of HM x weekly Day _____ Funding _____
			___ Units of HM x weekly Day _____ Funding _____
		_____ **CHORE**	___ Units of Chore or Home Repair x weekly Day _____
		HOME REPAIR _____ _____	Funding _____

Identified Problem or Need (Describe)	Goals	Services	Provider Formal/Informal Units/time/ funding source
Social: (mental/emotional)	___ Enhance/maintain highest level of functioning ___ Client to be safe and supported ___ Enhanced quality of life of the client ___ Enhanced quality of life of the caregiver Other _____ Other _____	**SOCIAL SERVICES** ___ Referral ___ Telephone Reassurance Visiting Friendly Legal Assistance Transportation Volunteer opportunities Senior activites Other **RESPITE** Adult Day Center/ Alzheimer's Respite **OR** In-Home Respite ___ Reality Orientation ___ Recreational activities ___ Individuals/groups Socialization ___ Exercise/gait training ___ Education ___ Other Other	___ Units of _____ ___ x weekly Day _____ Funding _____ ___ Units of ADC/Alz. Respite ___ x weekly Day _____ Funding _____ ___ Units of In-Home Respite ___ x weekly Day _____ Funding _____
Economic (Income/lack of resources)	___ Establish/enhance or maintain client's ability to support self Other _____ Other _____	**BENEFITS** Assistance in applying for benefits Guardianship/ conservator Payee Money Management Teaching Benefits Counseling Other	___ Units of _____ ___ x weekly Day _____ Funding _____ ___ Units of _____ ___ x weekly Day _____ Funding _____
Other:	Other _____ Other _____		___ Units of _____ ___ x weekly Day _____ Funding _____ ___ Units of _____ ___ x weekly Day _____ Funding _____

"I have reviewed and agreed to the care plan. I have read and had explained to me the Quality Assurance procedure and have received a copy of the agreement."

Client _____, _____ **Clients initials**

Case Manager _____, **Date** _____

Adult Day Center Director _____, **Date** _____ **(Adult Day Director should use different color of ink when completing Adult Day Services if completed on different date.)** 7/96

1. Social Security # ☐☐☐☐☐☐☐☐☐

2. Date of Referral ___/___/___ MM DD YY

3. Date of Intake ___/___/___ MM DD YY

Date of Initial Assessment ___/___/___ MM DD YY

State of Kentucky
Aging Services

Client Enrollment

5. Priority #

6. Case Type _____ A, B, C, D, E, F

7. Worker Initial _____

8. ADD # _____

9. Provider # _____

10. Initial Program
- ☐ Title III
- ☐ Homecare
- ☐ Adult Day
- ☐ LTCM
- ☐ PCAP
- ☐ SSBG
- ☐ Other (Specify)

12. Medicare #

13. Medicaid #

14. Client Name (Last, First, Middle)

15. Phone #

16. Address (Street and Number)

17. Date of Birth ___/___/___ MM DD YY

11. Status
- ☐ Initial Enrollment Title III
- ☐ Enrollment Update Title III
- ☐ Re-enrollment - Title III
- ☐ Service Update
- ☐ Client Closure
- ☐ Initial Assessment
- ☐ Reassessment

18. City and State

19. Zip

20. County Code (Residence) ___ 3 digits

21. Title III - Under 60 as:
- ☐ 01. Spouse
- ☐ 02. Disabled
- ☐ 03. Staff
- a 04. Volunteer
- ☐ 05. Guest

22. Area of Residence
- ☐ o & i & l
- ☐ 02. Rural

23. Sex
- ☐ 01. Female
- ☐ 02. Male

24. Written Communication

Reading ☐ ☐ ☐ ☐

Writing ☐ Yes ☐ N o

25. Language
- ☐ 01. English
- ☐ 02. Spanish
- ☐ 03. Other/Unknown (Specify) _____

26. Citizenship
- cl 01. U.S.
- ☐ 02. Other (Specify) _____

27. Race
- 01. Asian/Pacific Island.
- 02. Am. Indian/Alaskan Origin
- ☐ 03. African American
- ☐ 04. Hispanic
- ☐ 05. Non-Minority
- ☐ 06. Not Reported

28. Marital Status
- ☐ 01. Never Married
- ☐ 02. Separated
- ☐ 03. Widowed
- ☐ 04. Divorced
- ☐ 05. Married
- ☐ 06. Not Reported

29. Household Composition
- ☐ 01. Lives Alone
- ☐ 02. With Spouse
- ☐ 03. With Children
- ☐ 04. With Relatives
- ☐ 05. With Non-Relatives
- ☐ 06. Not Reported

 # in Household

 # in Family

30. Title III- Annual Household Income (Optional)

(Greatest Economic Need automatically calculated below)

31. Homecare - Family Income
- ☐ 01. 0,000 - 3,000
- ☐ 02. 3,001 - 4,000
- ☐ 03. 4,001 - 5,000
- ☐ 04. 5,001 - 6,000
- ☐ 05. 6,001 - 7,000
- ☐ 06. 7,001 - 8,000
- ☐ 07. 8,001 - 9,000
- ☐ 08. 9,001 - 10,000
- ☐ 09. 10,001 - 12,000
- ☐ 10. 12,001 - 15,000
- ☐ 11. 15,001 - 18,000
- ☐ 12. 18,001 - 21,000
- ☐ 13. 21,001 - Above
- ☐ 14. Not Reported

32. Enrollment/Entitlements
- ☐ 01. Medicare ☐ Part A ☐ Part B
- ☐ 02. Medicaid
- ☐ 03. Medicare Supplement
- ☐ 04. Private Health Ins.
- ☐ 05. Health Related
- ☐ 06. Food Stamps
- ☐ 07. SSI
- cl 08. Veterans Benefits
- ☐ 09. Social Security
- ☐ 10. Retirement
- ☐ 11. None
- ☐ 12. Other (Specify) _____

33. Greatest Economic Need

☐ ☐ ☐ ☐

34. Homecare Referral Source
- ☐ 01. Family
- ☐ 02. Physician
- ☐ 03. Hospitals
- ☐ 04. Alternate Care Facility
- ☐ 05. Home Health
- ☐ 06. Health Department
- ☐ 07. State Agency
- ☐ 08. Title III
- ☐ 09. Friends/Neighbors
- ☐ 10. Self
- ☐ 11. Homecare
- ☐ 12. Churches
- ☐ 13. Housing Managers
- ☐ 14. Other (Specify) _____

35. Please check services the participant may receive
- ☐ 01. *Adult Day/Adult Day Health
- ☐ 02. Advocacy/Representation
- ☐ 03. Assessment
- ☐ 04. *Case Management
- ☐ 05 * Chore Service
- ☐ 06. Counseling
- ☐ 07. Education/Training
- ☐ 08. Employment
- ☐ 09. Friendly Visiting
- 10. Health Promotion
- 11. Home Health Aide
- ☐ 12. Home Repair
- ☐ 13. *Homemaker
- ☐ 14. Information and Assistance
- ☐ 15. Legal Assistance
- ☐ 16. Meals - Congregate
- ☐ 17. *Meals - Home Delivered
- ☐ 18. Nutrition Counseling
- ☐ 19. Nutrition Education
- ☐ 20. Outreach/Client Finding
- ☐ 21. *Personal Care
- ☐ 22. Recreation
- ☐ 23. Respite
- ☐ 24. Telephoning
- ☐ 25. Transportation
- ☐ 26. Assisted Transportation (Escort)

Diet
- ☐ Regular
- ☐ Special (Specify) _____

*For items with asterisk, must complete ADL and IADL Section - six services for Title III.
Complete Nutritional Risk Assessment for Items 4, 16, 17, and 18 for Title III.

Client Name

36. Age Verification

- ☐ 01. Birth Certificate
- ☐ 02. Driver's License
- ☐ 03. School Record
- ☐ 04. Passport
- ☐ 05. U.S. Census Records
- ☐ 06. Employment Identification Card
- ☐ 07. Military/Veteran's Identification Card
- ☐ 08. Notorized Affidavit
- ☐ 09. Wedding or Divorce Decree
- ☐ 10. Social Security-Medicare Card (Category M certifies 65 or older)
- ☐ 11. Other- Describe _____

37. Nutritional Risk (Check all that apply)

Points	
0	☐ 0. None
2	☐ 01. I have an illness or condition that made me change the kind and/or amount of food I eat.
3	☐ 02. I eat fewer than 2 meals per day.
2	☐ 03. I eat few fruits or vegetables, or milk products.
2	☐ 04. I have 3 or more drinks of beer, liquor or wine almost every day.
2	☐ 05. I have tooth or mouth problems that make it hard for me to eat.
4	☐ 06. I don't always have enough money to buy the food I need.
1	☐ 07. I eat alone most of the time.
1	☐ 08. I take 3 or more different prescribed or over-the-counter drugs a day.
2	☐ 09. Without wanting to, I have lost or gained 10 pounds in the last 6 months.
2	☐ 10. I am not always physically able to shop, cook and/or feed self.
	Total Points ____ Score 6+ = High Nutritional Risk

38. Client's Physician _____ Phone No. _____

Preferred Hospital _____ Phone No. _____

Pharmacy _____ Phone No. _____

Emergency Contact _____ Phone No. _____

Emergency Contact Address _____

Do you have an Advance Directive: ____ Yes ____ No Describe _____

Location of Document _____

/ Legal Guardian / Power of Attorney (Describe) Effective Date Phone No.

39. Caregiver's Name _____ Phone No. _____

Caregiver's Address _____

Spouse's Name _____ Phone No. _____

Spouse's Address _____

Children: Name (Additional space on back) Address Phone No.

40. Directions to Home:

Statement of Confidentiality

The information recorded on this form is required for the statistical and reporting requirements for State and Community Programs under the Older Americans Act of 1965, as amended [Public Law 89731], and is not to be used for any other purpose in any form which could identify the individual without the individual's knowledge of the specific use and the individual's specific authorization for such use.

41. Closure Information - Closure Date

Closure Reason ____ ___/___/___ MM DD YY

- ☐ 00- Ineligible
- ☐ 01- Died
- ☐ 02- Moved
- ☐ 03- To Personal Care/Family
- ☐ 04- To Nursing Facility
- ☐ 05- Condition Improved
- ☐ 06- Client Request
- ☐ 07- Services not needed
- ☐ 08- Transferred to Title III
- ☐ 08a- Transferred to Homecare
- ☐ 09- Transferred to Day Care
- ☐ 10- Transferred to Another Agency/Prog.
- ☐ 11- Other (Specify) _____

] Reassessment

ADL/IADL ASSESSMENT/REASSESS.

Client Name

Respondent Name

Title III Need Circle Y or N

DEGREE OF ASSISTANCE NEEDED

ADLs		NONE	MINOR	MUCH PHYS.	COMPL. ASSIST.	NEEDS MET BY (NAME OF FAMILY/FRIEND/OR AGENCY)	NEEDS UNMET	TOTALLY MET	PART. MET	FRE-QUENC
F ELF	Y N									
TRANSFER	Y N									
TOILETING	Y N									
BATHING/ GROOMING	Y N									
DRESSING	Y N									
WALKING	Y N									

EDBOUND Yes ____ No ____ CHAIRBOUND Yes____ No ____ WHEELCHAIR MOBILITY Yes ____ No ____

Title III Need Circle Y or N

DEGREE OF ASSISTANCE NEEDED

IADLs		NONE	MINOR	MUCH PHYS.	COMPL. ASSIST.	NEEDS MET BY (NAME OF FAMILY/FRIEND/OR AGENCY)	NEEDS UNMET	TOTALLY MET	PART. MET	FRE-QUENCY
MEAL PREPARATION	Y N									
SH NG/ E OS	Y N									
LIGHT HOUSE WORK Dishes/ Dusting	Y N									
HEAVY HOUSEWORK Vac./Mopping	Y N									
PAY BILLS/ HANDLE MONEY	Y N									
JSE TELEPHONE	Y N									
MEDICATION MANAGE-MENT	Y N									
LAUNDRY	Y N									
TRANSPORTA-TION ABILITY	Y N									

omments: _____

Sect P.

(For Additional Space Write On Back)

00 Edition

_____Assessment

Client Name:_____

Respondent:_____

PHYSICAL HEALTH (Self Reported)

1 Health _____Excellent - - _____Fair _____Poor

Please indicate health problems experienced during the past 12 months by checking the block if client reports problems.

_Anemia (low blood)
_Arthritis/Rheumatism
_Back Problems
_Cancer/Leukemia
_Circulation Problems
_Cirrhosis
_Constipation
_Diabetes (Sugar)
_Foot or Nail Problem
___Gout
___Heart Problems
___High Blood Pressure
___Injuries from fall/accident
___Jaundice
___Lung Problems
___Osteoporosis (bone loss)
-Paralysis
___Parkinson's Disease (Palsy)
___Prostate Enlargement
___Recent Surgery
___Shingles
___Stroke
___Urinary Tract Disorder
___Vertigo (Dizziness)
___Tb
-Hepatitis
___MRSA
___Other (Specify)
_____

Medical Conditions or Diagnoses: _____

_____

_____

_____

_____

Do you receive any of the following treatments or therapies? Check all that apply.

___InhalationRx
___Oxygen
___Suctioning
___I.V. fluids
___Tube feedings
___Aseptic dressing
___L&on irrigation
___Insulin therapy
___Decubitus care
j. ___Sp skin care
k. ___Sp foot care
l. ___Catheter Irrigation
m. ___Ostomy care
n. ___Bowel-bladder rehabilitation
o. ___I.V. medicines
p. - P.T.
q. ___O.T.
r. ___S.T.
s. ___A.&b.-Trans. training
t ___Exercise
u. -Blood tranfusions
v. ___Other (Specify)
_____
_____

Providers'_____

_____

Weight _____ Height _____

INCONTINENT Yes___ No___ BOWEL___ BLADDER___

OSTOMY_____ URINARY CATHETER_____

Do you smoke, dip or chew tobacco? _____

Skin Condition: - S o f t ___Dry ___Flakey ___Intact

___Broken ___Reddened ___Rash

Notes on Health Conditions _____

_____

_____

_____

_____

_____

_____

Client Name:_____

, PHYSICAL HEALTH (Continued)

Medications
(prescribed and over the counter)

Medicine	Dosage	Frequency	Purpose	Doctor

edication allergies _____

cohol and Drug Assessment

lowing is a list of questions. The questions refer to your experiences over the last two years. The questions ıcern alcohol, prescription and other drug use. In these questions, alcohol refers to beverages such as wine, beer, iskey; prescription drugs refers to medications prescribed by a doctor; over-the-counter medications means dications you can purchase without prescription; other drugs refers to illegal drugs. There are no right or wrong swers.

	YES	NO
Do you drink alcohol?	-	-
How often? _____		
What do you drink? _____		
Do you use other drugs?		
How often? _____		
What drugs? _____		

DTES TO ASSESSOR: If the response to anypf the items l-2 is yes, proceed to the following set of estions. (If all responses to the above questions are no, please end this part of the interview.)

late the following questions to the substances which the client answered positively to in the above estions "l-2". For example, if a client only responded to "es" to drinking, and "no" to prescription l other drugs, then question #3 would be read like this: Has your use of alcohol caused you a ıl n?

0 Edition

Client Name: _____

II. PHYSICAL HEALTH (Continued)

	YES	NO
3. Has your use of alcohol, prescription drugs or other drugs caused you a problem?	___	
a. What type of problem do you have? _____		
4. Have you had any problems related to alcohol, prescription drugs or other drug use (e.g., liver disease, ever had blackouts or memory losses)?	___	___
5. Have you felt you should cut down on your drinking, prescription drugs or other drug use?	___	___
Has anyone (e.g., family member, friend, doctor) expressed concern that you used too much alcohol, prescription drugs or other drugs?	___	___
6. Have you used prescription medication without a prescription or more than was prescribed for you?	___	___
7. Is a referral for treatment or counseling needed?	___	___

8. How often do you see a doctor? _____
   Date of your last visit: _____ Purpose: _____
9. How often do you see a dentist? _____
   Date of your last visit: _____ Purpose: _____
   Do you wear dentures? ___ Do they fit well? _____
   Do you have any dental problems? _____
10. Number of times institutionalized in the past 6 months? (Where, why, how long) _____
11. Hospital/Emergency or Nursing Home _____
12. Are you on a waiting list for nursing home placement? ___Yes ___No

Nutrition

13. Would you say your appetite is: Excellent ___ ___ ___ Fair Poor
14. Do you require a diet modification? Yes ___ No ___
    Date physician's order last written? _____
    DIET MODIFICATION: ___ Diabetic ___ Fat Restricted ___ Sodium Restricted ___ Mechanical Soft ___ Other
15. How many glasses of liquid/fluid do you drink a day? _____
16. Has your physician presaii any supplements? Vitamin/Mineral _____ Liquid' _____
17. Are there foods you do not eat for religious reasons? _____
18. Do you have any known food allergies? If yes, explain.
19. Is there any diet related information not previously questioned which should be included? _____

Client Name: _____

SECTION IIL ASSISTIVE DEVICES, SENSORY IMPAIRMENT AND COMMUNICATIONS

Comments:

PHYSICAL SUPPORT EQUIPMENT	Has	Uses	Needs
BED PAN			
BEDSIDE COMMODE			
ELEVATED TOILET SEAT			
TUB SEAT			
GRAB BARS			
CANE/CRUTCHES			
WALKER			
HOSPITAL BED			
LIFT CHAIR			
RAMP			
WHEELCHAIR			
PROSTHESIS			

SENSORY IMPAIRMENT:

ION (with glasses if used)
Adequate
__ 2. Difficulty seeing print
__ 3. Difficulty seeing objects
__ 4. No useful vision
__ 5. Not determined

ABILITY TO TASTE/SMELL
__ 1. No Complaints
__ 2 Reduced
__ 3. Greatly Reduced
__ 4. Absent

COMMUNICATION
__ 1. Communicates needs/can beunderstood .
__ 2. Communicates needs with difficulty/can be understood
__ 3. Communicates needs with' Sign language/gestures
__ 4. Inappropriate content
__ 5. Unable/does not communicate

If client uses/ has glasses-lenses:
When did you last see an eye doctor? _____
Renewed prescription for g i a s s e s ? . _____

HEARING (with hearing aid if used)
__ 1. Adequate
__ 2. Hearing difficulty at level of conversation
__ 3. Hears loud sounds only
__ 4. No useful hearing
__ 5. Not determined

TOUCH
__ 1. Numbness or tingling inextremities
__ 2 Unusually sensitive or or intolerant to heat or cold

If client has hearing aid:
When did you last have a hearing test? _____ RESULTS: _____

Is specialized evaluation needed for Impairment? _____

nents: _____

Client Name _____

SECTION IV. PHYSICAL ENVIRONMENT . .

Lives in: House- Apartment __ Other___ Amount of rent: _____
client Owns___ Rents(Subsidy)___ Other- .. utilities: _____
Landlord: Name: _____
Address: _____
_____ Comments:
Telephone: _____

Check each category	Yes	No	Needs Repair
Sound building			
Sound furnishings			
Running water/(hot/cold)			
Adequate heating/cooling			
Tub/shower/commode (accessible and useable)			
Stove/microwave			
Refrigerator			
Freezer space			
Telephone (accessible and useable)			
TV/radio			
Washer/dryer			
Adequate space			
Adequate lighting			
Adequate locks			
Neighborhood safe/secure			
Insect/Rodent problem			
Free of fire/safety/health hazards			
CO-Detector; Smoke Detectors			
Physical Barriers: stairs, narrow doorways			

Is client satisfied with present living arrangements? Yes __ NO -
Does client plan to move? Yes___ No___ .
Plans _____
_____
Does client have pets? Yes___ No___ If yes, what kind? _____
Indoors _____
Outdoors _____
Comments _____
_____
_____

Client Name _____

SECTION V. FORMAL/INFORMAL RESOURCES

If you have a caregiver, how has your illness or disability affected the caregiver?

_____

_____

_____

_____

_____

SUPPORT SYSTEMS

Informal:

'Name/Relationship	Address	Phone #

Formal:

Agency/Worker	Address	Phone # .

POTENTIAL SYSTEMS

Name/Relationship	Address	Phone # .

Client Name _____

SECTION V. (Continued)

ACTIVITIES:

Hobbies/special interests
(In-home/out-of-home) _____

If no longer active with hobby, how long ago did client stop activity and why?

Participation at Senior' Center or Adult Day Center: _____

Former Occupation: _____

VOLUNTEER ACTIVITIES
Present: _____

Past: _____

Would you like an opportunity to volunteer in some capacity? _____

FAMILY INTERACTION:

RELIGIOUS AFFILIATION: _____
Attends Services: _____
Has In-Home Visits from Clergy or Congregation: _____

Listen To: Radio/TV Services: _____

Client's Name _____

CTION VI. MENTAL/EMOTIONAL STATUS

he client has responded to the request for information for this assessment – beginning with the intake
as responded appropriately and accurately, the assessor can go to the "need help at night"
n. Enter N/A if the assessor does not complete the Mental Status Questionnaire and initial

N/A _____ Case Manager/Assessor Initials _____

Mental Status Questionnaire

	CORRECT	ERROR
Where are you now? What place is this?	_____	_____
What is the name of this place?	_____	_____
Where is it located(address)?	_____	_____
What is the date today? Day? (Score correct if within three days)	_____	_____
Month?	_____	_____
Year?	_____	_____
How old are you?	_____	_____
When were you born? Month?	_____	_____
Year of birth?	_____	_____
Who is president of the United States?	_____	_____
Who was president beforehim?	_____	_____

ou need help at night, how would you obtain it? _____

Mental Health Screening

next questions are mainly about how you have been doing in the last six months.

	Yes	No
lave you had a lack of interest in most activities, and/or had low r sad moods?	—	—
lave you had brief, sudden attacks of shortness or breath, rapid eart beat, shaking or fearfulness? (If answered yes, isregard if related to medical diagnosis.)	—	—
o you hear or see things other people do not seem to'notice?	—	—
o you think someone is reading or controlling your thoughts?		—
o you think anyone is especially against you?	—	—
lave you had severe nightmares?	—	—
lave you any thoughts about harming yourself?	—	—
o you want to strike someone or destroy property when you get ngry?	—	—
a you received counseling treatment for personal problems or nal stress in the past 12 months?	—	—

0 Edition

Client's Name _____

SECTION VI. (Continued)

If yes, for what reason _____

Physician/Agency providing treatment: _____

Would you be willing to accept assistance to receive treatment? _____

Describe any behavior problems identified by client or observed by Case Manager and how it effects client's functioning.

List recent major changes or crises that may be affecting client:

Comments:

Client's Name _____

SECTION VII. SUMMARY AND JUDGEMENT

Specialized evaluation/consultation necessary (describe):

CABINET FOR HEALTH SERVICES
COMMONWEALTH OF KENTUCKY
FRANKFORT, 4062 l-000 1

DEPARTMENT FOR MEDICAID SERVICES
"An Equal Opportunity Employer M/F/D'

MEMORANDUM

TO: Local Office
Department for Community Based Services
Cabinet for Families & Children

FROM: _____
(Facility/Waiver Agency)

SUBJECT: _____
(Recipient Name) (Social Security/Medicaid Number)

_____
(Previous Address)

_____
(Responsible Relative's Name & Address)

This is to notify you that the above-referenced recipient

c l was admitted to this facility/waiver agency _____ (Date)
is in Title _____ (XVIII or XIX) Payment Status, and was placed in a

☐ NF bed ☐ ICF/MR/DD bed ☐ MH bed

☐ Home & Community Based Service ☐ SCL Waiver Service and/or

☐ was discharged from this facility/waiver agency on _____ (Date)
and went to _____
(Home Address/Name & Address of New Facility/Waiver Agency)
and/or expired on _____ (Date)

☐ was re-instated to Home & Community Based or SCL waiver services within 60 days of the NF admission. _____ (Date Re-Instated)

For Home & Community Based waiver *Clients only* - last date service was provided _____. (Date)

_____
(Siinature)

MAP-24 (Rev. 0112000)

EDUCATION